Outpatient Prospective Payment System (OPPS) Seminar, October 10, 2006 Questions and Answers

Michigan Department of Community Health
MDCH
Jennifer M. Granholm, Governor
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On site question: Does this seminar pertain to Outpatient Mental Health Billing?

Answer: The OPPS Project and this seminar applies to all currently enrolled Medicaid provider type (PT) 40's (outpatient hospitals, hospital-owned ambulance services, freestanding dialysis centers, comprehensive outpatient rehabilitation facilities (CORF's), and rehabilitation agencies (PT 40's) for services provided on and after April 1, 2007.

Reference slide 29 -30, and MSA Bulletin 06-47 issued July 1, 2006.

Web question: Please repeat the Med learn Matters Update to Repetitive Billing Instructions in Medicare Claims Processing Manual number.

Answer: MM4047. Reference slide 60 & 71 and/or visit the MDCH OPPS web site.

Web question: Will Medicaid follow the same guidelines as Medicare for Observation Services?

Answer: To be decided. Information specific to Medicaid Observation Services coverage will be published in a separate bulletin.

Reference slide 46.

It was announced at the Michigan Medicaid Hospital Workgroup October meeting effective April 1, 2007, Medicaid will use Medicare's Observation criteria.

Web question: How will ambulance services be impacted by Medicaid OPPS?

Answer: Under OPPS hospital-owned ambulance services (currently enrolled as provider type 18) will be required to make a provider enrollment and billing format change. MDCH will assist you if you are a hospital-owned ambulance services with becoming enrolled under their outpatient hospital existing Medicaid ID number and bill for services using the institutional claim formats (UB 92 and/or 837I). MDCH will retain its current ambulance coverage policies and fee schedule for all ambulance services.

Referenced proposed policy MSA 06-46-OPPS which was released for public comment 10-09-06.

Refer to slide 29 & 30 MSA Bulletin 06-47 issued July 1, 2006, and MSA 06-46 in public comment.

Web question: How do you calculate the pricing for APCs and where are the resources to locate this information?

Answer: Under OPPS, HCPCS drive reimbursement and the Revenue Code is for cost reporting. Medicare's OPPS website and the final rule contain information regarding the specific calculations and formulas under the APC methodology.

Reference slides 7 & 8, 14-20, and 39

Web question: Will this apply to health plans such as the Upper Peninsula Health Plan?

Answer: Yes. All Michigan Medicaid Health Plans follow MI Medicaid's proposed OPPS.

Reference slides 28 – 32.

Web question: Does it matter if you bill using a TOB 131 v. TOB 851 for CAH Medicaid bills?

Answer: If you currently bill Medicare using TOB 85x, our claims processing system will internally crosswalk to TOB 13x and process accordingly. For any Medicaid primary claims after OPPS implementation, please use the appropriate OPPS TOBs listed in the final OPPS policy.

Web question: How will "old" claims with a date of service (DOS) prior to (OPPS Implementation) 4-01-07 be processed and what billing rules apply?

Answer: Medicaid PT 40 claims for DOS on/before 3-31-07 must be billed under the current PT 40 policy.

Reference slides 28 & 32.

All Medicaid PT 40 claims for DOS on/after 4-01-07 must be billed under the new OPPS policy and billing guidelines.

Web question: If a beneficiary signs an ABN prior to services, do we still have to report the test to Medicaid as non-covered?

Answer: It is individual hospital protocol/preference in reporting non-covered services. If Medicare is primary, hospitals should follow Medicare's ABN guidelines for medical necessity vs. not medically necessary. If Medicaid is primary, individual hospitals must decide whether or not to report non-covered services. Medicaid is unable to track/trend non-covered services if they are not reported.

Web question: Do we need to be specific with reporting Revenue Codes – will this affect reimbursement?

Answer: Under OPPS, HCPCS drive reimbursement and the Revenue Code is for cost reporting. A Revenue Code is required on each claim line. Medicare's OPPS website and the final rule contain information regarding the specific calculations and formulas under the APC methodology.

Reference slides 7 & 8, 14-20, and 39.

Web question: Will Medicaid still do diagnosis code editing on ER claims under OPPS?

Answer: Medicaid will continue to review the 051 diagnosis list/edit after OPPS implementation to determine if we need to continue monitoring ER.

Web question: What is the target date for Medicaid/Medicare cross over claims, and will the billing process be the same?

Answer: There is no target date at this time. Medicaid must successfully implement OPPS before we begin working on processing Medicare/Medicaid cross over claims. Yes – the billing process will be the same.

Reference slide 48

Web question: Will Revenue Code 0821 (Dialysis) be affected?

Answer: Dialysis coverage remains unchanged except for DOS on/after 4-01-07 Medicaid OPPS requires that you report a claim line HCPCS code. Dialysis HCPCS codes are published on the Wrap Around Code list (available on the OPPS web site). Reimbursement remains the same.

Refer to MSA Bulletin 06-46 for Other OPPS/Non-APC Services information.

Reference slides 43, 46, 47 and 71.

On site question: How does OPPS impact services paid at percent of charge – how is this calculated and will you use the facility cost-to-charge ratio (CCR)?

Answer: Under OPPS, we will use the current Medicaid Outpatient Hospital CCR without applying the statewide reduction factor.

Reference slide 45.

On site & APC mailbox question: Is money required on each charge line like in claim example number 2?

Answer: No – this is an example only - and individual hospital preference in reporting a total charge and "zero charge" on subsequent claim lines, or to report money across the claim lines.

The APC Manager recommends when multiple surgical procedures are performed at the same session, it is not necessary to bill separate charges for each procedure. It is acceptable to bill a single bill as a single charge under the Revenue Code that describes where the procedure was performed, on the same claim line as one of the surgical HCPCS.

On site question: Are Rural Health Clinics (RHC's) still billed on a CMS 1500 for Medicaid and on the UB for Medicare?

Answer: Yes

On site question: Do we have to do a claim replacement for late charges or can it be billed on a separate claim? For example, a lab test not submitted on the original claim.

Answer: You must do a claim replacement and all services for a single outpatient visit/encounter must be submitted on one claim, per Medicare billing guidelines.

On site question: What Long Term Care TOB should we bill for Medicaid secondary to Medicare for Part B co insurance – TOB 13X or 22X?

Answer: Continue to bill the appropriate TOB 22X.

On site question: Will the Medicaid reduction factor be the same for everyone and will it ever change?

Answer: Yes. The reduction factor will be the same for everyone and it will be evaluated on an ongoing basis post implementation. Please closely monitor the OPPS website for information regarding the reduction factor that will be published in a Medicaid OPPS proposed 'financial' OPPS bulletin.

APC Mailbox Question: Do we need to bill all of our charges on one claim if they are secondary to Medicare? Charges were combined when Medicare was billed but not all are APCs; and charges were combined and all are APC charges?

Answer: Yes, combine as one claim for a single date of service.

All services for a single outpatient encounter must be reported on one claim, except for Medicare's allowable repetitively billed services and hospital-owned ambulance services.

The Medicare Status Indicator (SI) identifies the APC v non-APC assignment. The OCE finds the highest weighted APC and applies the SI logic for discounting or packaged services.

Under Medicaid's OPPS, the Medicare OPPS SI processing logic for (e.g., Medicare discounting process) is applied first, followed by the MDCH reduction factor.

APC Mailbox Question: We are an inpatient rehab that bills Medicaid using PT40 but are not paid under OPPS by Medicare – does Medicaid OPPS apply to us?

Answer: Yes. All Medicaid-enrolled PT 40s as well as hospital-owned ambulance services will be reimbursed utilizing Medicaid's OPPS methodology.